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ABSTRACT

The materials contained in this guide are intended to indicate possibilities, to identify minimum criteria, and to encourage public school involvement in drug education for adults. Part I of the guide discusses essential concepts; leadership elements; program content; and ways of gaining valid insights into the culture of youth, especially as it relates to drugs. Part II is a basic outline summarizing the characteristics of the principal drugs; and a guide for discussion and for further reading. Part III, an annotated bibliography, represents a cross section of some of the important literature current in the field of drugs and narcotics. (PT)

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF EDUCATION

A GUIDE FOR DIRECTORS O
CONTINUING EDUCATION

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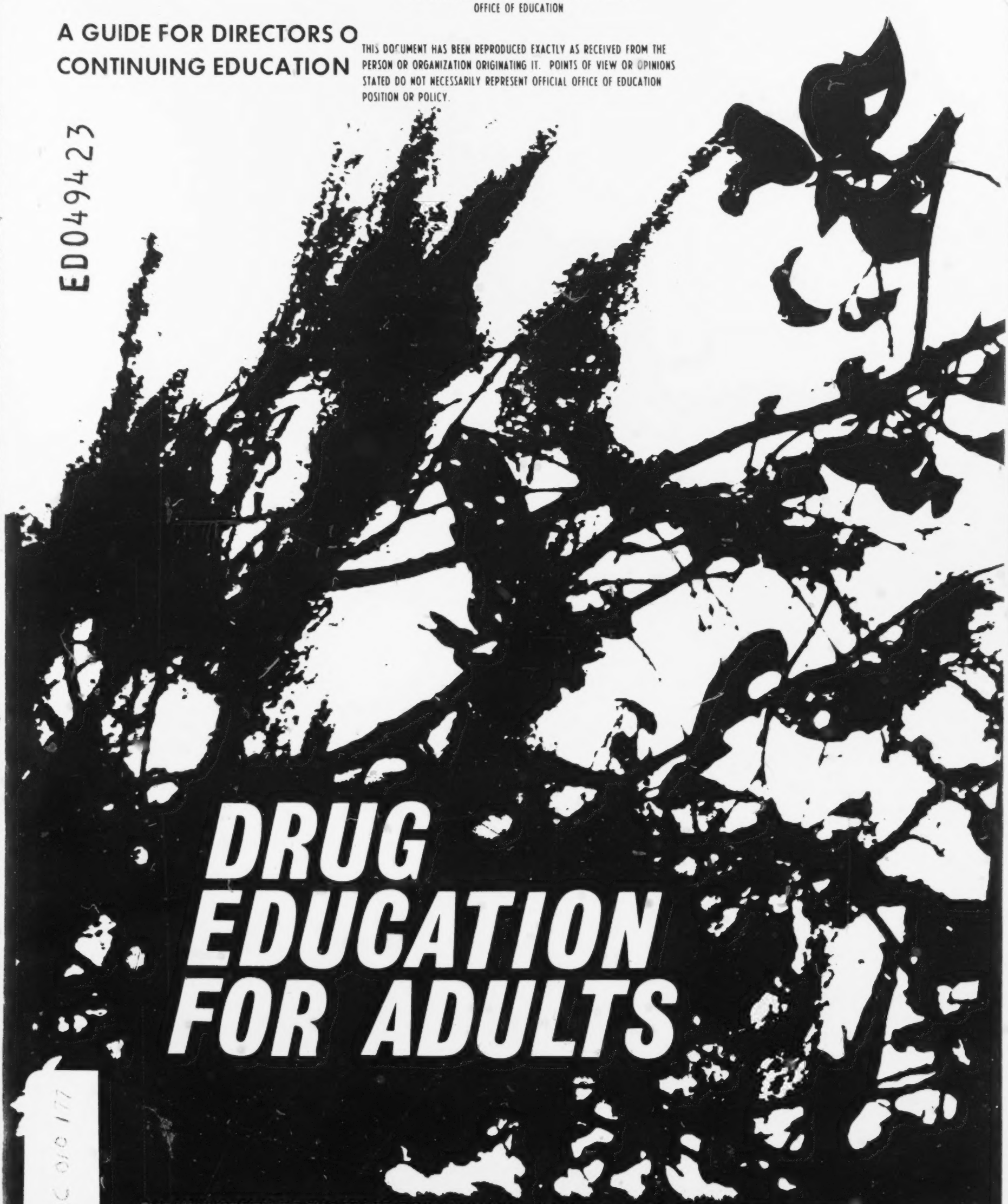

DRUG EDUCATION FOR ADULTS

AC 016 177

THE UNIVERSITY OF THE STATE OF NEW YORK / THE STATE EDUCATION DEPARTMENT
BUREAU OF SPECIAL CONTINUING EDUCATION / ALBANY, NEW YORK 12224

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Part I

DRUG ABUSE:
THE CONTINUING EDUCATION PERSPECTIVE

No topic suggests more urgency for continuing education than drug abuse. Perceived in its entirety, drug abuse is a societal problem. It is not an exclusive problem of youth, nor is it confined to the inner city.

The issues of drugs and narcotics include the misuse of prescription drugs just as surely as they encompass turning on with mescaline or marihuana.

In considering the hazards of drug and narcotics abuse we need to be concerned with the housewife who gets hooked on barbiturates, the businessman who gets strung out on amphetamines, and the student who feels he needs to take dexedrine in order to study for examinations. Perhaps we need to be just as concerned about these kinds of drug abuse as we are about young people smcking pot. Emphatically, the use of hard narcotics, especially by young people, is an urgent social concern.

Solutions to these kinds of problems will be determined only with the support of the entire community. These are not the sort of issues which can be resolved by interested segments of the community, nor by the police, and certainly not by pretending that they are not present.

The director of continuing education has a front line responsibility. His position is unique with regard to community education about drug abuse. He coordinates the education of adults in a publicly supported institution which has responsibility to every member of the community. Furthermore, the director of continuing education is likely to have daily contact with both young people and adults.

We have not often thought of the combined role which most directors of continuing education play as being

especially productive to continuing education. In the case of education about drug abuse, the fact that a director of continuing education may also be a teacher, a guidance counselor, or a school administrator could be beneficial in helping to build programs which will help to bring about the kind of community consciousness which is necessary for finding reasonable solutions to the drug abuse problem.

The materials contained in this package are intended to indicate possibilities, to identify minimum criteria, and to encourage public school involvement in drug education for adults.

In Part I, the list of Essential Concepts is aimed at providing a base for building understanding of the elements to be considered in developing a continuing education program on drug abuse.

The section on Leadership Elements should help to identify for school leadership some of the kinds of people in his own and neighboring communities who can give knowledge and direction. Hopefully, it will suggest still other sources of leadership.

The delineation of Program Content is not intended as a fixed series of items. It does represent some of the facets of the drug problem which communities need to know about in order to cope sensibly with them.

Gaining Valid Insights points the way toward giving adults access to the culture of youth, especially as it relates to drugs.

Part II of this package is a basic outline, summarizing the characteristics of the principal drugs in question. It is a guide for discussion, covering essential elements, and it is offered with the hope that it will encourage further reading.

Part III, an annotated bibliography, represents a cross section of some of the important literature current in the field of drugs and narcotics. The Bureau of Special Continuing Education will be sending supplementary resource lists as they are developed.

Do not hesitate to call upon this Bureau for assistance in program development, community relations, and the selection and procurement of materials and leadership for continuing education programs on drug abuse.

ESSENTIAL CONCEPTS

Certain concepts need to be considered in planning continuing education programs on drug abuse:

1. We live in a drug using society. People look to drugs for relief from a variety of physical, psychological, and social afflictions - with varying effectiveness.

   Young people brought up on television have been told that pills reduce anxiety, relieve tension, and provide buffers for everyday living. Is there a relationship between the advertisements of tranquilizers to face daily living, liquor for celebration, and the use of marihuana at a rock concert?

2. Educational efforts that do not cover the entire spectrum of drugs invite youthful charges of hypocrisy. A good continuing education program gives the facts about drugs, and it distinguishes between drug use, misuse, and abuse.

3. Sensationalism and exaggeration hurt the effectiveness of drug education. Many young people will be in a position to measure adult statements against empirical knowledge.

4. The relation of drug use to other personal and social problems is complex and without pat answers. One fact does consistently emerge in talks with counselors, users, and others knowledgeable of the drug scene. Drugs are not the initial cause of dropping out from school or society. They are, instead, the consequence.

5. It is important to distinguish between drug abuse, and prescribed, scientific, and reasonable use of drugs for the treatment of illness.

LEADERSHIP ELEMENTS

The director of continuing education will want to expose adults in his community to as wide a variety of speakers and other program leaders as possible. This does not refer to presenting a disjointed potpourri, but it does mean presenting a spectrum of attitudes, disciplines, and opinions.

Locating qualified persons requires considerable time, effort, and judgment. Largely by consulting with numbers of people, stimulating meaningful dialog, and by asking many questions will the right programing decisions be made. Spokesmen should be selected not for the authoritative positions they hold but for the valid information they can communicate. Their ability to relate to people should rate high consideration.

Given for example an anesthesiologist who is chairman of a county medical society and a general practitioner, the director of continuing education might choose the first, unless he had found out by investigation that the practitioner had done clinical research on the use of drugs and was sought after by young people as a medical authority and confidant.

A balanced program does not mean a simple <u>yes</u> and <u>no</u> format, unless the intention is to use conflict to generate discussion. Not much can be gained from a program which consists of one speaker arguing for the legalization of marihuana and another speaking against it. A better way would be to assume no immediate change in the laws and to examine from a variety of viewpoints the positions of students and others who hold that marihuana laws are inequitable and, therefore, should be violated.

The best place to begin looking for program leadership is right in your own community. Start with a halfway house, a local counseling agency, a research project at a nearby hospital. The range of personnel extends from ministers to disc jockeys and from physicians to coffee house operators. Additional sources of leadership include:

1. Colleges and universities: departments of psychology, pharmacology, sociology, anthropology, medical schools, law schools, teachers colleges.

2. Mental health agencies: public health units; other health organizations.

3. Physicians; psychiatrists.

4. Police and law enforcement officers who relate to the community scene.

5. Juvenile courts; juvenile detention centers; prison administrators.

6. Student leaders of school and church organizations.

7. Teachers conducting successful drug education programs.

8. YMCA, Boy Scout, and other youth organization leaders.

9. Social welfare organizations; child guidance centers; hospital personnel.

10. Press representatives; editors of underground papers.

11. Musicians popular with student groups.

12. VISTA and Job Corps staffs; the managers of runaway location centers found in some locations.

13. Ex-addicts; ex-alcoholics.

14. Community narcotics guidance councils.

15. Public school personnel: health educators, counselors, teachers, and administrators who relate particularly well to youth.

PROGRAM CONTENT

Considering the many aspects of drug and narcotics education that could be covered in a continuing education program, the main topics in a reasonably comprehensive program would include:

1. Brief history of drugs and drug use.

2. Pharmacology of drugs including alcohol and tobacco: effects, addictive qualities.

3. Psychological aspects: personalities predisposed to drugs; society's stake in drugs; characteristics of the drug subculture; value systems; moral implications; true and false notions about drugs; youth alienation and protest; counseling services.

4. Legal aspects: local and Federal drug laws; law enforcement; judiciary, parole, and probation; possible changes in laws; how to counsel apprehended youngsters.

5. Research: latest findings on effects and side effects of drugs or lack of them; statistics; future trends.

6. Student views on drugs vs. community views.

7. Financial aspects.

8. Drugs in religious or mystical experiences.

9. Alternatives to turning on with drugs.

10. Explanation of drug education as taught in the schools should be part of a total health education program.

Alternative viewpoints should receive honest consideration in treating each of the above topics. Opposing "good" and "bad" approaches are not productive in drug education.

In planning a program for adults it could be highly useful to gain advice on content from students representing a cross section of student body.

GAINING INSIGHTS

It would be extremely effective if adults participating in drug education programs could gain deeper insights

into drug and narcotics issues than would be usually possible within the confines of classrooms, lecture halls, or libraries. If at all possible, establishing field visits or experiential situations would do much to help adults understand what is really happening behind the scenes of their daily routines. It must be recognized at the outset that many of the learning experiences would not be possible for large groups, nor for entire classes. However, there is nothing to preclude participation in field trips and other experiential situations by smaller groups and by individuals, thus creating within the class a wide variety of experiences which can then be related via reports and other presentations to all the program participants. Experiential possibilities could include individual or small group visits to:

1. Halfway houses, if they will permit operators to talk with patients, staff; ex-addicts on staff may be especially helpful.

2. Juvenile detention centers, to observe instances of arrest and incarceration and to hold discussions with staff and defendants facing incarceration in a detention center or jail, with the experience of being locked in or working for one day as an aid in a withdrawal hospital or treatment center for firsthand observation of drug effects.

3. Courthouses for discussions with judges, lawyers, prosecutors, probation officers, possibly defendants.

4. Mental hospitals and drug treatment units for discussion and observations.

5. Young peoples' meeting places - churches, stores, inns, parks, youth centers.

6. Houses for runaways and crash pads or drop-in houses for young drug addicts.

7. Rock music halls - psychedelic sounds and lights, radio stations with audience participation rock programs. Here the leadership should indicate in particular the young peoples' reaction to bombardment of the senses and how they enjoy the stimulation of immersion in sound, sight, and rhythm combined with kinetic activity

(dancing). Contrast these with the less stimulating activities of the classroom. The adult participants might be wise to contrast their own feelings at the end of the evening at a rock den with their feelings after a usual evening at home in front of the TV.

8. Youth-audience movie houses.

9. High school chemistry department or college of pharmacology for practical information and observations about drugs.

10. Research laboratories to observe drug experiments.

11. Offices of social workers for observations and interviews.

12. Where practical, visits to local schools for observation of both desirable school situations and those which may not be deemed conducive to good behavior.

ADVANTAGES

Continuing education programs should take advantage of as many opportunities as possible to observe the drug scene and the drug subculture from a variety of points of view. A visit to a hospital could provide an opportunity for interviews with staff members and patients to learn their views of the drug problem. It is highly advisable in order to assure productive interviews and to insure against failures that directors of continuing education and program leaders check out field trips and interviews in advance.

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Part II

EDUCATION ABOUT DRUG ABUSE

AN OUTLINE FOR DIRECTORS OF CONTINUING EDUCATION

The following outline is intended as a guideline for school districts in planning programs on drug abuse and to indicate to consultants and other program leadership the essential elements which ought to be covered.

The drug and narcotics issue is complex. The accompanying resource list will help provide at least some of the knowledge required, as will talks with the kinds of people listed in the accompanying section on program leadership (Part I, Page 4).

MARIHUANA

I. WHAT IS MARIHUANA?

A. How is it used?
B. How widely is it used in the United States?
C. How widely is it used in your community?
D. How does the drug work?
E. What are its physical effects?
F. What are its other effects?
G. How does it affect judgment?
H. What does recent research tell us about marihuana?
I. What does it look like?
J. How is it distributed in the United States?
K. Why is so little known about the drug?

II. IS MARIHUANA ADDICTIVE?

A. What is meant by drug dependency?
B. What is the difference between dependence and addiction?

C. Does marihuana lead to narcotics use? Predisposition to drug abuse, what are the signs?
D. Does one develop tolerance?

III. WHAT ARE THE LAWS DEALING WITH MARIHUANA?

A. The Federal laws; the State laws.
B. How are narcotics laws enforced locally?
C. How are violators treated in the courts?

IV. WHAT ARE THE SPECIAL RISKS FOR YOUNG MARIHUANA USERS?

A. Career consequences of conviction.
B. Effects on growth and development, personality, physical health.

V. RESEARCH UNDERWAY.

UPS AND DOWNS

AMPHETAMINES AND BARBITURATES

I. AMPHETAMINES - THE "UP" PILLS.

A. Stimulants to central nervous system.
B. Benzedrine (bennies).
C. Dexedrine (dexies).
D. Methedrine (speed).

II. HOW THESE DRUGS AFFECT MOODS.

A. Check fatigue.
B. Produce alertness, self confidence.
C. Jitteriness, irritability, tension, unclear speech.
D. Depression hangover and letdown feeling.

III. PHYSICAL EFFECTS.

A. Heart and blood pressure increase.
B. Palpitations.
C. Dilation of pupils.
D. Headache.
E. Diarrhea.
F. Loss of appetite.
G. Sweating.

IV. HOW THESE DRUGS WORK.

A. Production of norepinephrine (substance stored in nerve endings).
B. Speeding up of heart and metabolism.

V. MEDICAL USES OF AMPHETAMINES.

A. Colds and allergies.
B. Weight control.
C. Depression.
D. Unwanted reactions.

VI. MISUSE OF STIMULANTS.

A. A national problem encompassing all age groups and occupations: housewives, businessmen, students, athletes, truck-drivers.
B. Twenty percent of all medical prescriptions.* Fifty percent of this supply used illegally.*
C. Black market laboratories also produce stimulants which are easily obtained from illegal sources.

VII. ARE THESE STIMULANTS ADDICTIVE?

A. Development of tolerance.
B. Psychological dependence.
C. Mental and emotional consequences.

VIII. DAMAGES OF STIMULANT DRUGS.

A. Cause people to perform beyond endurance.
B. Toxic psychosis (mental derangement).
C. Auditory and visual hallucinations.
D. Withdrawal problems of heavy users - suicidal depression.
E. Long range effects: social, intellectual, emotional.
F. Special dangers of injecting "speed" (methamphetamine).

*From a report by the Pure Food and Drug Administration cited in "Facts on Drugs," The National Institute of Mental Health.

BARBITURATES, THE "DOWN" PILLS

I. WHAT ARE SEDATIVES?

A. Barbiturates.

1. Phenobarbital sodium (nembutal) fast acting.
2. Secobarbital sodium (seconal) fast acting.
3. Penobarbital (luminal) slow starting, long acting.
4. Amobarbital (amytal) slow starting, long acting.
5. Butabarbital (butisol) slow starting, long acting.

B. Short acting preparations, most commonly abused (barbs, goof balls).
C. One in four prescriptions written by M.D.'s is for barbiturates.

II. MEDICAL USES.

A. High blood pressure.
B. Insomnia.
C. Epilepsy.
D. Mental illness.
E. Relax patients before and during surgery.

III. NATURE OF THEIR EFFECTS.

A. Normal doses depress action of nerves, muscles, slow heart rate and breathing, lower blood pressure.
B. Higher doses: effect of drunkenness, impairment of speech, concentration, coordination, deep sleep.

IV. DANGERS OF BARBITURATES.

A. Commonly found in homes because they are frequently prescribed by M.D.'s.
B. People mistakenly consider them safe and use them freely.
C. Overdose can cause death.
D. Distortion of perception.
E. Slow down responses.
F. Important causes of automobile accidents.
G. Heighten effects of alcohol.
H. Variation of effects, reactions vary in intensity from one time to another.

I. Leading causes of accidental poison deaths.
J. Means of committing suicide.

V. ARE BARBITURATES ADDICTING?

A. They are physically addicting, also psychologically.
B. Body needs increasingly higher doses to feel effects (tolerance is developed).
C. Withdrawal sickness.

VI. THE LEGAL CONTROLS.

A. Regulated by Bureau of Narcotics and Dangerous Drugs in the Department of Justice.
B. Regulations -

1. Manufacturing.
2. Selling.
3. Prescribing.
4. Penalties.

D-LYSERGIC ACID DIETHYLAMIDE = LSD

I. WHAT IS LSD?

A. A powerful man-made chemical.

1. So powerful that 1 ounce provides 300,000 average doses.
2. Classified as hallucinogen - a mind affecting drug.
3. Illegal in United States (except for government approved research).

B. Other hallucinogens or psychedelic drugs:

1. Peyote.
2. Mescaline.
3. Psilocybin.
4. DMT.
5. STP.

II. WHY PEOPLE TAKE LSD.

A. Kicks and curiosity.
B. Religious and philosophical experience.
C. "Consciousness expanders" of other times: opium, nitrous oxide, ether - claims no longer made that they provide path to wisdom and insight.
D. LSD use dropping off - at least in some areas.

III. PHYSICAL EFFECTS OF LSD.

A. Average dose (usually a speck) lasts 8 to 10 hours.
B. Taken in capsule form, sugar cube, or crackers.
C. Increases heart and pulse rate.
D. Rise in temperature and blood pressure.
E. Dilation of eye pupils; cold, sweaty palms.
F. Face flushed or pale.
G. Shivering, chills, goose pimples.
H. Irregular breathing, loss of appetite, nausea.
I. Not physically addicting.

IV. PSYCHOLOGICAL EFFECTS.

A. Sudden changes in sensory perception.

1. Walls appear to move.
2. Colors seem stronger, more brilliant.
3. Users likely to see unusual patterns unfolding before them.
4. Flat objects seem to stand out in three dimensions.
5. Taste, smell, hearing, touch seem more acute.
6. One sensory impression may be translated or merged into another; for example, music may appear as color, and colors may seem to have a taste.
7. Users report loss of normal feeling of boundaries between body and space.
8. Feeling of two strong but opposite reactions at same time, e.g., sad and happy, relaxed and tense.
9. Effects variable and unpredictable; hence, good and bad trips.

V. HOW DOES LSD AFFECT THINKING?

A. Loss of sense of time.

B. Incomplete recall of events while under drug's effects.
C. New insights and questions of consciousness expanding results of LSD.

VI. HOW DOES LSD WORK?

A. Precisely how it works in body not fully known.

1. Affects levels of chemicals in brain.
2. Produces changes in brain's electrical activity.

B. What experiments indicate:

1. Normal filtering and screening out processes of brain become flooded with unselected sights and sounds.
2. Studies of chronic users -

a. Indicate continuation of overload of stimulation to their senses.
b. This overload may impair regular user's ability to concentrate on goal.

VII. IS LSD DANGEROUS?

A. Definite dangers reported from unsupervised use.

1. Panic and fear resulting from user's inability to stop drug's action.
2. Paranoia - may last up to 72 hours after drug has worn off.
3. Recurrence - experiences while under influence of drugs may recur days, even months, later.
4. Accidental death - sometimes resulting from feeling of great power.
5. Fears which may accompany LSD experience can cause acute mental illness.

VIII. LSD AND BIRTH DEFECTS.

A. Chromosome damage.

1. Temporary vs. permanent cell damage(?).

B. Research still underway.

1. Authorities consider LSD definite risk.

IX. THE LEGAL VIEW OF LSD.

A. Classified as dangerous drug.

1. Closely regulated by Bureau of Narcotics and Dangerous Drugs, Department of Justice.
2. Strict penalties for producing, selling, possessing with intent to sell.

NARCOTICS

HEROIN, MORPHINE, CODEINE

I. WHAT ARE NARCOTIC DRUGS?

A. Generally refers to pain killing drugs obtained from juice of poppy fruit.

		Source
1.	Heroin	semi-synthetic from morphine
2.	Morphine	natural from opium
3.	Codeine	natural from opium, semi-synthetic from morphine
4.	Paragoric	natural and synthetic

B. Synthetic narcotics.

1. Demerol.
2. Dolophine.
3. Meperidine.

C. Heroin is narcotic most widely used by addicts.

II. WHAT IS NARCOTIC ADDICTION? (GETTING HOOKED)

A. Body requires repeated and larger doses of drug.

1. Development of body tolerance, cross tolerance is developed.

B. Withdrawal sickness.

1. Symptoms.
2. How long does physical addiction last?

C. Psychological dependence.

1. Emotional reasons.
2. Narcotics is a way to escape facing life.

III. WHAT IS THE EFFECT OF HEROIN?

A. Emotional reactions.

1. Reduction of tension.
2. Easing of fears.
3. Relief from worry.

B. Physical aspects.

1. Depresses certain areas of brain.
2. Reduction of hunger, thirst, sex drive.
3. Withdrawal symptoms appear about 18 hours after discontinuance.

C. General effects.

1. Determined by user's personality.
2. Size and frequency of dose.
3. How drug is taken.

IV. WHO TAKES NARCOTICS?

A. 60,000 addicts listed by Bureau of Narcotics.
B. More than half live in New York State.
C. Chiefly among younger men of minority groups in ghetto areas.
D. More than half under 30 years of age.
E. The other half of the statistics.

1. Who are they?
2. How and why are they getting hooked?

V. THE LIFE OF A HEROIN ADDICT.

A. Chief concern is getting supplies.
B. A day's supply runs from $75 to $100.
C. How addiction leads to crime.
D. Life is a continuous preoccupation with getting heroin, experiencing effects, getting over effects, and facing withdrawal.

VI. WHAT ARE THE LEGAL PENALTIES?

A. The Harrison Act of 1914.

VII. THE MEDICAL VIEW OF ADDICTION.

A. The addict is a sick person.
B. Treatment needed:

1. For physical addiction.
2. For psychological dependency.
3. For withdrawal sickness.
4. Help to keep person from going back to drug use.
5. Handling post "high" period, including near stupor.
6. Prevention of narcotic fatalities.

a. Overdose.
b. Unexpectedly paradose.
c. Spread of disease (hepatitis).

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Part III

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POLLARD, JOHN C. and UHR, LEONARD - Drugs and Phantasy, the Effects of LSD, Psilocybin and Sernyl on College Students. Little, Brown and Co., Boston, Mass. ($7.50) A series of case studies of LSD, psilocybin and sernyl experiences. Each student subject relates his experiences.

ROBINSON, M. NYSWANDER - The Drug Addict as Patient. Grune and Stratton, New York 1956 ($6.95) Physicians who have treated narcotic addicts describe various approaches used in private practice and institutional care. It may be useful to a wide variety of professional people in contact with addicts.

ROPP, ROBERT S. - Drugs and the Mind. Grove Press, New York 1957 (95¢) A biochemist discusses the mental effects of chemicals in the brain and on the brain. The book is 12 years old, but still generally valid.

SCHUR, EDWIN M. - Crimes Without Victims: Deviant Behavior and Public Policy. Prentice-Hall, Englewood Cliffs, N.J. 1965 ($1.95) The classic plea for attention to public policy concerning abortion, homosexuality, and drug-taking.

SIMMONS, JERRY L. and WINOGRAD, BARRY - It's Happening. Brandon House, No. Hollywood, Calif. 1966 ($1.95) Widely read by college students. This sociological study of the goals, ideals, and activities of the affluent college drug users is a subcultural study written for the layman.

SOLOMON, DAVID (ed.) - The Marijuana Papers. Bobbs-Merrill Co., Indianapolis, Ind. 1966 ($10.00) Reprint of some classic and out-of-print papers dealing with marijuana. Divided into sections considering: 1) historical, sociological, and cultural; 2) literary and imaginative, and 3) scientific.

TAYLOR, NORMAN - Narcotics: Nature's Dangerous Gifts. Delta Publishing Co., New York 1963 (75¢) (also Dell $1.65) Despite the misleading title, a sound lay description of many of the mind-altering drugs.

Pamphlets

NARCOTICS (PHS 1827), LSD (PHS 1828), Marihuana (PHS 1829), The Up and Down Drugs (PHS 1830). Supt. of Documents, U.S. Government Printing Office, Washington, D.C. 20402 (5 cents each or $3 for 100, except Marihuana is $3.75 for 100). These flyers, produced by the National Institute of Mental Health, use questions and answers to describe each drug and to describe mood effects, physical effects, medical uses, misuses, and research.

TASK FORCE REPORT: - Narcotics and Drug Abuse. Supt. of Documents, U.S. Government Printing Office, Washington, D.C. 20402, 1967 ($1.00). Annotations and Consultants' Papers of the Task Force on Narcotics and Drug Abuse, the President's Commission on Law Enforcement and Administration of Justice. Gives recommendations for control, research, education, treatment, civil commitment, and coordination of Federal level programs. Could be considered a textbook for educators, college and senior high school students.

Periodicals

DRUG DEPENDENCE - National Clearinghouse for Mental Health Information, NIMH, Chevy Chase, Md. 20015. Published at random intervals. Addressed to the scientific and medical community and other concerned professionals. Contains selected items covering recent developments in the field and identifies citations to the current abstracts available from NCMHI.

UN BULLETIN ON NARCOTICS - United Nations Publications, Rm. 1059, UN Bldg., New York 10017 (quarterly, $2 per year). Official notices of reports of meetings and actions taken by United Nations, including World Health Organization, which relate to drugs. Contains original scientific research papers and review articles.

THE INTERNATIONAL JOURNAL OF THE ADDICTIONS - Issued semiannually by the Institute for the Study of Drug Addiction, 680 West End Avenue, New York 10025 ($6.00 per year). Provides a worldwide forum of exchange among professionals participating in research

training, and treatment in the field of addictions and substance misuse. An international editorial board, comprised of members of the various medical professions, focuses on all facets of substance misuse -- drug, alcohol, tobacco, and food.

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